

Application to Extend

New York State Section 1115 Demonstration Project No. 11-W-00114/2

The Partnership Plan

March 29, 2002

Overview

In July 1997, New York State received approval from the Health Care Financing Administration of its Section 1115 waiver request, known as the Partnership Plan. Approval of this waiver allowed the State to implement a mandatory Medicaid managed care program in counties with sufficient managed care capacity and the infrastructure to manage the education and enrollment processes essential to a mandatory program. The State's goal in implementing this program was to improve the health status of low income New Yorkers by:

- *improving access to health care for the Medicaid population*
- *improving the quality of health services delivered*
- *expanding coverage to additional low income New Yorkers with resources generated through managed care efficiencies*

New York's 1115 waiver expires on March 31, 2003. With CMS approval, it is New York State intent to continue the significant progress made towards achieving its goals by extending the waiver pursuant to Section 1115(e) of the Social Security Act.

Project Status

New York began implementation of the Partnership Plan immediately after receiving federal approval. The State had a well established voluntary Medicaid managed care program prior to the waiver. Implementation of the mandatory program has been phased in geographically with the first 5 counties beginning in October 1997. Implementation in New York City began in August 1999. To date, New York has implemented the mandatory Medicaid managed care program in 19 counties and Phase 1, 2 and 3 areas of New York City. CMS has also approved implementation in two additional counties, Wayne and Livingston. The State is currently operating voluntary Medicaid managed care programs in 25 counties. Six of these counties are expected to convert to mandatory programs in 2002. In addition, the State anticipates receiving CMS approval to implement the Phase 4 and 5 areas on New York City in late spring, 2002. Statewide, Medicaid enrollment has grown from approximately 650,000 in July 1997 to 900,000 as of March 2002.

In May 2001, CMS approved an amendment to the 1115 waiver to provide for implementation of the Family Health Plus program enacted by State legislation. This program provides comprehensive health coverage to adults with children with income up to 150% of the federal poverty level and to single adults with income up to 100% of the federal poverty level. The State began accepting applications into this program in September 2001. New York City enrollment was delayed until February 2002 as a result of the World Trade Center disaster. As of March 2002, Family Health Plus enrollment has reached approximately 14,000 enrollees.

Program Objectives

As previously detailed, New York's primary objectives in mandating managed care enrollment for much of the State's Medicaid population were to increase access, improve quality and to expand coverage to low income New Yorkers. Significant success has been achieved in each of these program objectives as documented below.

Access

An important goal of the Partnership Plan has been to improve access to healthcare services for the Medicaid population and improving access to primary care services has been a key objective. Analysis conducted by the State Department of Health (SDOH) as well as analysis done by independent external entities has documented significantly improved access under the Medicaid Managed care program.

To assess the effectiveness of the Partnership Plan in this area, the SDOH, Office of Managed Care (OMC) conducts periodic analysis of physician participation in both Medicaid managed care plans and the Medicaid fee-for-service program. The most recent analysis of primary care and ob/gyn physicians, based on 4th Quarter 2001 HPN data, indicates the following:

	<u>Fee-for-Service Participating*</u>	<u>Managed Care Participating*</u>
New York City	5,181	7,157
Rest of State	6,650	8,035
Total	11,831	15,192

**includes primary care physicians and ob/gyns*

In addition, the Center for Health Workforce Studies (CHWS) within the School of Public Health, SUNY Albany, recently conducted a study of physician participation in the Medicaid Managed Care program, focusing on New York City. A copy of their report is enclosed for your information. The study was conducted under contract with the United Hospital fund and key findings of the study were:

- 38% of NYC primary care physicians participate in Medicaid managed care while only 21% participate in the Medicaid fee-for-service program
- Primary care physicians participating in Medicaid managed care appear to be better qualified than both Medicaid fee-for-service physicians and the overall NYC primary care physician pool, as measured by board certification rates, completion of accredited residency programs and the percentage of physicians with hospital admitting privileges.

CHWS also found that while there are substantially more primary care physicians participating in the Medicaid managed care program, most managed care enrollees are concentrated with a relatively small number of these physicians. This is true to an even greater degree in the fee-for-service program. The study also found that the high volume managed care physicians are well distributed in areas of high need and that many of the low volume physicians are distributed across the city, a possible indication of the additional capacity available as the mandatory program expands.

Quality

In implementing a mandatory Medicaid managed care program, New York's primary goal has been to improve the quality of care for this population. The Partnership Plan has established a new standard for accountability in health service delivery to New York's Medicaid population. The State's quality assurance monitoring is among the most sophisticated in the nation and provides State and federal agencies, health plans, providers and, most importantly, consumers with information about the quality of care delivered by managed care plans, in addition to information about member satisfaction.

New York has been publishing quality measures for Medicaid managed care since 1994. The reports, entitled *New York State Managed Care Plan Performance*, are published annually and the about to be released 2001 report is enclosed for your information. The data are obtained through the annual collection of data known as the Quality Assurance Reporting Requirements (QARR). The reports contain information on managed care quality, access, utilization and satisfaction for plans that serve Medicaid managed care enrollees. Calendar year 2000 Medicaid managed care data show significant improvement has been achieved in a number of critical quality measures since measurement began in 1994. The following chart provides examples of areas that have shown such improvement.

Measure	1994	2000
Cervical Cancer Screening	43%	71%
Breast Cancer Screening	50%	64%
Immunization 4-3-1-1	59%	72%
Lead Testing	64%	76%

Data also show that the State is exceeding national Medicaid benchmarks in a number of areas. The table below shows New York State performance compared to national HEDIS Medicaid data.

Measure	1999 National Medicaid Benchmark	1999 Medicaid QARR Rate	2000 Medicaid QARR Rate
Childhood Immunization (4-3-1-2-3)	53.7	64.5	63.5
Adolescent Well Care	29.3	40.8	Not Collected
Cervical Cancer Screening	60.0	70.1	71.1
Prenatal Care First Trimester	59.2	60.0	60.5
Check Ups After Delivery	48.2	54.5	61.0
Eye Exams for Diabetics	40.4	40.4	49.5
Access to Primary Care Providers			
12-24 Months	85.2	83.1	86.3
25 Mos. – 6 Years	74.8	77.0	81.1
7 – 11 Years	75.9	76.4	82.3
Well Child Visits Ages 3,4,5,6 Years	51.2	69.4	Not Collected

To achieve these results, OMC has worked closely with managed care plans on quality improvement activities. Quality Performance matrices are prepared for all plans using QARR data. Plans are asked to prepare root cause analyses and action plans for HEDIS/QARR measures that are identified for improvement. Over the three years this process has been in effect, fewer measures have required action plans as a function of improved performance. A paper describing this process entitled *The Quality Performance Matrix: New York State's Model for Targeting Quality Improvement in Managed Care Plans* was published in the Winter 2001 issue of the Quality Management in Health Care Journal.

The State has also made extensive efforts to assure that quality data concerning managed care plans is available to Medicaid beneficiaries. Quality data is published in regional brochures entitled "A Consumer's Guide to Medicaid Managed Care". These guides are available in local district offices and are now included in the enrollment packets sent out by Maximus in New York City. In addition, in November 2001, eQARR 2001- An Interactive Report on Managed Care Performance was made public on the New York State Department of Health's website. eQARR 2001 is based on results of 2000 QARR and the Consumer Assessment of Health Plans survey (CAHPS). In addition to descriptions of measures included and plan/county service area information, rates and significance for the following measures of quality and satisfaction are included:

- **Prenatal and Postpartum Care:** Timeliness of Prenatal Care, Vaginal Birth After Cesarean Section, and Postpartum Care.

- **Child and Adolescent Care:** Childhood Immunization, Lead Testing, Well-Child and Preventive Care Visits in the First 15 Months of Life (5+ Visits), Adolescent Well-Care and Preventive Health Visits and Appropriate Medications for Asthma (5-17 Years).
- **Adult Care:** Breast Cancer Screening, Cervical Cancer Screening, Appropriate Medications for Asthma (18-56 Years), Diabetes Eye Exam, Diabetes Poorly Controlled, and Antidepressant Outpatient Follow Up.
- **Satisfaction with Care:** Problem Getting Care Needed, Problem with Service, Rating of Receive Services Quickly, Rating of Provider Communication, Rating of Personal Doctor or Nurse, Rating of Specialist, Rating of Health Plan, Rating of Health Plan by Frequent User of Service, Called or Written Complaints, and Recommend to Friends.

eQARR provides rates for standardized quality measures for twenty-four commercial and twenty-nine Medicaid and Child Health Plus plans. Statistical ratings comparing plans to statewide averages, by region, are also provided. Regional results are grouped into the following six regions: Central; Hudson Valley; Long Island; New York City; Northeast and Western. An electronic survey is also provided to elicit feedback from consumers on the design and content of eQARR 2001.

In addition, the Department requires plans to participate in focused clinical studies. Subjects of the clinical studies have included asthma care; referral to specialists; prenatal screening and adolescent preventive care. The reports are reviewed for best practice information that can be disseminated to all the plans.

The Department has also, in collaboration with advisory groups, developed a study design for a focused clinical study and a quality improvement project as follows:

- **Emergency Room Utilization** – The objective of this study is to identify strategies MCOs can use to effect ER usage by investigating current patterns of ER use; MCO policies and procedures to monitor ER use; and how the ER episode is coordinated with the enrollee's primary care provider. A sampling plan was determined and two surveys were developed: a) one for Medicaid managed care ER users and, b) one for MCO administration.
- **Chlamydia Testing** – An analysis of rates of chlamydia testing for Medicaid managed care enrollees was conducted using MEDS and MMIS data. A workgroup was formed to investigate potential barriers to improving the rates of screening for the Medicaid population.

In an important new initiative, the Department of Health recently released an RFA for grants to health plan for collaborative quality improvement projects. Up to \$1 million will be made available Medicaid managed care plans to fund these projects. Additional funding is available for commercial only plans. The State is pleased with progress made to date in these various quality improvement activities and looks forward to continuing these activities and initiating new ones under an extended waiver.

Expanded Coverage

A major objective of New York's 1115 Waiver has been expanding coverage. The State's expectation was that providing health care services to Medicaid beneficiaries through managed care plans would generate cost savings for both the State and Federal government. In approving the waiver, CMS concurred with this assessment and agreed to permit the State to use the cost savings generated to provide health coverage to other low income New Yorkers. In keeping with this goal, the waiver permits the State to receive federal match on nearly 240,000 Safety Net recipients who previously did not qualify for federal financial participation. In addition, in a major Medicaid expansion targeting low-income uninsured New Yorkers, the New York State legislature in December 1999 enacted legislation to provide comprehensive health coverage through a new program called Family Health Plus (FHPlus). FHPlus offers access to health care for an estimated 700,000 adult New Yorkers who are without health care coverage. The program provides comprehensive health care coverage to adults, with and without children, who have incomes or assets greater than the current Medicaid eligibility standards. Parent(s) living with a child under the age of 21 are eligible if the gross family income is up to: 133% FPL as of October 1, 2001; and 150% FPL as of October 1, 2002. Individuals without dependent children in their households qualify with gross incomes up to 100% FPL.

To provide for this coverage, an amendment to the 1115 waiver was submitted in June 2000. The amendment requested additional waivers of several provisions of the Medicaid statute and regulations so that New York State could expand eligibility consistent with the state legislation and receive federal financial participation in the costs of the FHPlus program. Through extensive discussions and analysis, the State was able to document that projected savings under the Partnership plan was sufficient to cover the cost of both the Safety Net population and the projected FHPlus enrollment. CMS approval of the program was received in May 2001 and program implementation began immediately.

Enrollment into FHPlus began in September 2001 for all areas other than New York City. Implementation in New York City was delayed until February 2002 as a result of the World Trade Center disaster and the resulting telecommunications damage, which seriously impeded access to the State's Welfare Management System. With CMS approval, the State implemented the temporary Disaster Relief Medicaid program and potential FHPlus eligibles were enrolled into this program through January 31, 2002.

Effective February 1, 2002, enrollment in FHPlus was available on a statewide basis and as of March 2002 there were more than 14,000 previously uninsured New Yorkers enrolled. Individuals enrolled in Disaster Relief Medicaid are currently being transitioned into either Family Health Plus or traditional Medicaid. Projections are that under a three-year extension of the waiver, FHPlus enrollment will reach 254,300.

Compliance with Terms and Conditions

New York State has worked diligently to assure compliance with the waiver Terms and Conditions (T&Cs). The Operational Protocol sets forth how the Partnership Plan is being implemented, consistent with the T&Cs. The SDOH has worked closely with CMS staff to assure that the Operational Protocol accurately reflects program operations and is kept up to date. CMS staff review and approve the Protocol to assure consistency with the T&Cs. SDOH has also made efforts to assure that program requirements are available to the general public, including posting the Operational Protocol on the Department's website.

Monitoring of program compliance is ongoing. OMC has conducted program reviews of local district operations to assess program implementation. Weekly conference calls have been conducted between SDOH, Maximus and New York City Department of Health (CDOH) and Human Resources Administration (HRA) staff to discuss operational issues, resolve problems and discuss program improvements. Local District and New York City Department of Health staff routinely monitor managed care plan marketing activities to evaluate compliance with marketing guidelines as set forth in the T&Cs and conditions. HRA conducts on site monitoring of Maximus operations on an ongoing basis.

CMS is able to assess State compliance with the T&Cs in numerous ways. Since the very beginning of the program, conference calls have been conducted first on a weekly basis and then biweekly to discuss program implementation, report on problems and address CMS requirements. CMS has conducted readiness reviews prior to each county's implementation and before each phase of NYC implementation to assure that program requirements can be met. SDOH also provides CMS with monthly, quarterly and annual reports on program activities as required by the T&Cs and routinely provides other reports as well. In addition, CMS staff generally monitor meetings of the Medicaid Managed Care Advisory Review Panel (MMCARP), an advisory body appointed by the Governor and the New York State legislature, where program activities are discussed in depth.

Through ongoing dialogue, program monitoring and regular and extensive reporting, New York State can assure CMS that it is in substantial compliance with the Partnership Plan's T&Cs.

Beneficiary Satisfaction

New York State monitors beneficiary satisfaction in several different ways. On a regular basis, SDOH looks at beneficiary complaints. The Department investigates all complaints it receives directly from beneficiaries, both through the complaint hotline established and complaints submitted in writing. In addition, SDOH requires that managed care plans provide detailed reports on beneficiary complaints they receive. Complaint data is analyzed by the Department to ascertain trends and to identify plans which may be outliers, in terms of either too many complaints or too few. Plans are required to provide explanation and/or corrective action on issues identified by the State through this analysis. Complaint data is also reported to CMS. SDOH also analyzes disenrollment data and beneficiary "switch" rates – the frequency with

which beneficiaries switch from one plan to another. All this data can provide indications of both general beneficiary satisfaction and satisfaction with particular plans.

In addition, SDOH conducts surveys of beneficiary satisfaction. Since program initiation, SDOH has conducted new enrollee surveys in New York City as required by CMS. These surveys indicate relatively little dissatisfaction among new enrollees. However, because they are conducted within several weeks of initial enrollment, many enrollees indicate it is “too soon to tell” how satisfied they are with their managed care plans. More useful in assessing beneficiary satisfaction has been the Consumer Assessment of Health Plan Survey (CAHPS).

SDOH conducts the CAHPS for the Medicaid population every two years. In the most recent survey, Roper Starch Worldwide Inc. was engaged to survey approximately 29,000 Medicaid managed care enrollees between May and September 2000. The overall response rate to the survey was 43%. Highlights of the survey include:

- 87% of enrollees gave a favorable rating for how well their providers communicate
- 77% indicated they received services quickly while 22% indicated some problem getting care
- 85% indicated they would recommend their plan to friends
- 11% indicated they had called or written their plan with a problem

Complete survey results were published in the 2000 QARR report. In general, the survey documents relatively high levels of beneficiary satisfaction. The next survey is being conducted in spring 2002.

Adequacy of Service Delivery Networks and Financing Mechanisms

Network Adequacy

New York has a variety of mechanisms for assessing the adequacy of the service delivery networks available to Medicaid managed care enrollees. First, plans are required to submit their networks to CMS on a quarterly basis. This is done online through the Health Provider Network (HPN). OMC staff reviews those networks to assure that each plan has all the required provider types. Staff also reviews these networks against provider sanction lists to assure that plans are removing sanctioned providers from their networks as appropriate. Plans with deficiencies are required to submit corrective action plans. At the end of 2001, plans reported a total of 64,349 individual providers who are available to Medicaid managed care recipients, of which 13,359 were PCPs.

As previously indicated, SDOH periodically does analysis to compare the overall Medicaid managed care network to the Medicaid fee-for-service network. This analysis consistently shows more provider participation in managed care networks than fee-for-service. To assess whether this participation is sufficient to meet the needs of projected future enrollment in managed care, SDOH also analyzes primary care participation by geographic area and need.

This capacity analysis was most recently done on a statewide basis in July 2001 to assess the adequacy of managed care provider networks for Phase III implementation of Medicaid managed care in New York City, and the Family Health Plus (FHPlus) program statewide. The analysis used current enrollment, FHPlus projections and projections of legal immigrants who will be eligible for Medicaid. The results showed that there were no Medicaid managed care participating counties with enrollee-to- PCP ratios over 600 to 1. In NYC, the ratio was 183 enrollees per PCP. The analysis also used projected Medicaid managed care enrollment to assess the provider networks in the five phase-in areas of New York City. This analysis also included the impact of FHPlus and legal immigrants. The results of that analysis showed all phase-in areas of New York City have enrollee-to-PCP ratios under 1,000 to 1. The conclusion of this analysis was that PCP capacity was more than adequate to implement Phase III in New York City and the FHPlus program statewide. Recently, SDOH provided CMS with updated analysis for NYC phases IV and V. Once again, the analysis showed sufficient capacity throughout NYC.

In addition to reviewing the networks submitted by plans for adequacy, SDOH conducts a number of audits of those networks. In 2000, plans were audited on the accuracy of their provider network data. For each of the 29 Medicaid plans, PCPs were randomly selected for audit. Of the 1,594 PCPs who were mailed surveys, 76.6% responded by confirming name and address information, license number, specialty, board certification, and hospital affiliation. In addition, respondents were asked whether the site was wheelchair accessible, how many hours the physician was at the site, panel status with the plan (open/closed), and what languages were spoken by clinical staff.

Name and address information was correct in at least 92.6% of the records. License number was correct for all but 10 responders. Wheelchair accessibility was reported correctly in 94.2% of the records. The survey also found underreporting of hospital affiliations and languages. Languages spoken increased 22.3% in audited records. The most common languages reported after English were Spanish, Hindi, French and Russian.

Audits are also conducted on access and availability of plan networks. Studies are conducted to assess the ability of providers in the Medicaid managed care program to make office appointments within specified time frames as well as to assess accessibility of providers after normal office hours. The access and availability studies for all MCOs in the upstate counties are generally conducted in May and June while the studies for the NYC plans are conducted in the fourth quarter of the year. After the studies are conducted, any plan scoring at or below 75% is issued a Statement of Deficiencies and is required to submit a Plan of Correction. These plans are then re-audited to ensure that their Plan of Correction has been implemented.

Finally, SDOH conducts provider directory surveys semi-annually. These consist of calling a sample of providers listed in the MCO's provider directory to determine whether or not the provider is participating in the plan, whether they serve Medicaid managed care members and whether or not they are accepting new Medicaid managed care members. The sample size is dependent on the size of the service area, but the minimum sample is 50 providers, and consists

of a variety of provider types representing all counties in the service area. When the participation of providers sampled is below 75%, a Statement of Deficiencies is issued and a Plan of Correction required. When the participation is above 75%, the plan is still provided with a listing of those providers that could not be contacted or were contacted and indicated they were not taking new Medicaid patients, or did not participate in the plan. The plan is advised to update their directory and make their members aware of the changes.

New York State expends significant resources to assure that Medicaid managed provider networks are adequate and accessible and has documented this to the satisfaction of CMS on numerous occasions. Most recent HPN data from plans (year-end 2001) show that managed care networks continue to grow and are more than sufficient to meet the needs of current and future managed care enrollees.

Financing Mechanisms

In general, New York State has established premium rates for managed care plans through individual negotiations with each participating plan. Plans provide SDOH with premium proposals reflecting the plan's historical cost experience as well projections for the rate year. For rates effective April 2002, the State is applying trend factors to the 2001 rates.

Plans have reported overall surplus from Medicaid operations for calendar year 2000 and surpluses continue as of the 3rd quarter 2001 Medicaid Managed Care Operating Reports, which is the most current information available. The average surplus for the PHSP's Medicaid line of business for calendar year 2000 was 5.2%, and for YTD 9/30/02 the surplus was 2.2%. For HMOs, the Medicaid line of business surplus for 2000 was 8.6% and for 2001 YTD 1.9%. Almost 70% of plans reported a net surplus YTD as of September 2001.

In addition to premium payments and consistent with federal laws and the waiver, supplemental payments are made directly to FQHCs and other comprehensive health centers that serve primarily Medicaid and indigent populations. These two transitional payment programs reimburse all or a portion of the per visit difference between what the clinic would have received under its fee-for-service rates and what it received under its managed care contracts. There are 32 clinics currently receiving supplemental payments. A total of \$28 million dollars has been paid on more than 806,220 Medicaid managed care clinic visits since the waiver began on October 1, 1997.

SDOH monitors financial solvency of plans and conducts financial capacity analysis of plans to assure that plans have adequate financial capacity to meet the projected enrollment needs. Plan financial solvency is reviewed on a quarterly basis. Key financial indicators reviewed are:

- (a) Net worth
- (b) Contingent reserve funds which cannot exceed 5% of the net premium income in a given calendar year.
- (c) Cash balance

(d) Escrow deposits which are required to reflect 5% of projected medical expenses for the next calendar year or \$100,000, whichever is greater.

A plan is considered impaired where its net worth is less than its contingent reserve or its available cash is less than its escrow deposit. As of September 30, 2001, two out of 30 Medicaid managed care plans were considered impaired. Both are commercial plans and are being closely monitored by the New York State Insurance Department.

A plan's financial capacity is determined by comparing its total projected medical costs for the upcoming year to its reserves and escrow deposit as required by State regulation. Each plan submits annually a projection of its expected total enrollment and associated medical costs for all counties for the upcoming year. Based on this projection, OMC calculates what each plan's required reserve and escrow deposit amounts would be, and compares them to the plan's actual amounts as reported on the plan balance sheet. Plans who meet the reserve and escrow requirements for the projected enrollment have met the capacity test. Plans that don't meet the test are required to either increase reserves/escrow, or reduce their projected enrollment.

Once the overall enrollment target is established, a monthly review is done to ensure that plans do not exceed their overall enrollment target. If a plan's enrollment does exceed the target, it must demonstrate that it has adequate reserves to increase the enrollment target, or additional enrollment into the plan is stopped pending such demonstration.

Currently, one plan, Vytra, has exceeded its approved projected enrollment capacity and enrollment has temporarily been stopped. The plan is financially capable of increasing its enrollment projections, but currently is in the process of submitting increased enrollment projections.

Compliance with Budget Neutrality Requirements

The Section 1115 waiver requires that the State demonstrate that the Partnership Plan is budget neutral. Under these provisions, New York State is subject to a limit on the amount of Federal Title XIX funding that the State may receive for certain Medicaid expenditures during the demonstration period.

On June 30, 2000, New York State submitted to the Centers for Medicare and Medicaid (then the Health Care Financing Administration) a request to amend the State's 1115 waiver to include Family Health Plus. In securing approval of that amendment, the State demonstrated not only that the Partnership Plan would achieve budget neutrality, but also that it would permit the expansion of health insurance coverage to adults eligible under Family Health Plus. That analysis has now been updated to reflect the most recent cost information and to extend the analysis through the extension period. Updated schedules of budget neutrality for the current 5-½ year waiver and the extended 8-½ year waiver have been provided to CMS staff as requested.

While the State has been successful in demonstrating budget neutrality for the initial term of the waiver, State specific Medicaid data show that trends in per member per month medical costs have increased significantly over those projected when the terms and conditions were agreed upon in 1997 based upon historical costs from federal fiscal years 1990 through 1994. Projections by the Centers for Medicare and Medicaid and the Congressional Budget Office, as well as surveys of privately sponsored healthcare programs, show similar patterns of increase in medical cost trends in other public and private programs. Fueled in part by successive years of double-digit increases in prescription drug costs and expectations of increases in hospital costs, experts agree that these trends will increase into future years. Based on an actuarial analysis of New York's historical Medicaid data and other relevant data conducted by the independent consulting firm William M. Mercer, the State is requesting a revision to the waiver for the three-year extension period to reflect an annual trend factor of 11.5% for all Medicaid Eligibility Groups (MEGs) specified in the waiver. Documentation in support of the requested trend factor has been provided to CMS staff as requested.

New York State will provide additional information as determined necessary by CMS with respect to the analysis of budget neutrality.

State Notice Procedure

Public Notice

New York has followed the state notice procedures as published in the *Federal Register* on September 27, 1994 and the consultation requirement with Federally recognized tribes as outlined in CMS's State Medicaid Director's letter of July 17, 2001. Both the public notice and tribal letter are attached for your information.

Using 2000 census data, cities with a population of 100,000 or more were identified. A public notice was published in the newspaper of widest circulation in each area on March 1, 2002. The chart below lists the cities and newspapers of publication.

It should be noted that these newspapers enjoy broad circulation in surrounding areas as well. For example, the *Albany Times Union* is circulated throughout the entire Capital region including Columbia, Greene, Saratoga and Rensselaer counties. The *New York Times* has virtually statewide circulation.

<u>Newspaper/City</u>	<u>Population</u>
<i>Albany Times Union</i>	95,658
Albany (Albany)	
<i>Buffalo News</i>	
Amherst (Erie)	116,510
Buffalo (Erie)	292,648
<i>Newsday</i>	
Brookhaven (Suffolk)	448,248
Hempstead (Nassau)	755,924
Huntington (Suffolk)	195,289
Islip (Suffolk)	322,612
North Hempstead (Nassau)	222,611
Oyster Bay (Nassau)	293,925
Smithtown (Suffolk)	115,715
<i>New York Times</i>	
New York City	8,008,278
Ramapo (Rockland)	108,905
Yonkers (Westchester)	196,086
<i>Rochester Democrat and Chronicle</i>	
Rochester (Monroe)	219,773
<i>Syracuse Post-Standard</i>	
Syracuse (Onondaga)	147,306

In addition to public notice in newspapers, the Department announced its intent to apply for an extension of the waiver at public meetings of the Medicaid Managed Care Advisory Review Panel on January 31, 2002 and March 19, 2002. The March 19th meeting included a discussion of CMS requirements for waiver extensions and the BBA requirement that extensions be granted under the same Terms and Conditions as the original demonstration.

Tribal Nations

New York State is home to 8 tribal nations, four of which are Federally recognized:

Cayuga Nation of Indians*	Oneida Indian Nation of New York*
Onondaga Nation	St. Regis Mohawk Nation*
Seneca Nation of Indians*	Shinnecock Indian Nation
Tonawanda Band of Senecas	Tuscarora Indian Nation
Unkechaug Indian Nation	

*Federally Recognized

Pursuant to CMS guidelines, SDOH advised the above mentioned tribes of our intent to request an extension of the 1115 waiver, The Partnership Plan. A copy of the letter sent the tribal nations is attached.

Extension Request

New York State is seeking a three-year extension of the Partnership Plan pursuant to Section 1115 (e) of the Social Security Act, as amended by section 4757 of the Balanced Budget Act of 1997. This application provides CMS with the assurances required under these provisions with respect to achievement of program objectives, compliance with T&Cs, beneficiary satisfaction, quality of care, adequacy of networks and financing mechanisms, compliance with budget neutrality requirements and evidence of public notice. Additional information can be provided as necessary to assist CMS in its review of this application to extend New York's 1115 waiver.

